

WiseChoices™ Benefit highlights

Coinsurance and copay represent WHAT YOU PAY.

All preferred provider services are NOT subject to deductible, and coinsurance is either 20% or 30%.

PCY - Per Calendar Year	WiseChoices 0 20		WiseChoices 0 30	
	PREFERRED	NON-PREFERRED	PREFERRED	NON-PREFERRED
Annual Deductible PCY (choose one) (family = 3x)†	None	\$3,000	None	\$3,000
Annual Coinsurance Maximum (family = 3x)†	\$9,500	Unlimited	\$9,500	Unlimited
Out-of-Pocket Maximum PCY (family = 3x)† (Includes annual deductible and coinsurance maximum; once met, Preferred Providers covered in full)	\$9,500	Unlimited	\$9,500	Unlimited
LIFETIME BENEFIT MAXIMUM	\$2,000,000		\$2,000,000	
COVERED SERVICES				
PREVENTIVE CARE				
Preventive Exams (includes routine medical exam, sports physical, men's and women's health exam and well baby exam)	\$30 Copay	50%	\$30 Copay	50%
Immunizations	Covered in full	Not covered	Covered in full	Not covered
Preventive Screenings (includes Pap smear, PSA testing, home colon cancer screening, cholesterol screening and bone density test)	Covered in full	50%	Covered in full	50%
PROFESSIONAL CARE				
Office Visits and Urgent Care	\$30 Copay	50%	\$30 Copay	50%
Outpatient and Inpatient Professional Services	20% (Coinsurance only)		30% (Coinsurance only)	
ALTERNATIVE CARE				
Spinal and Other Manipulations 12 visits PCY	\$25 Copay		\$25 Copay	
Acupuncture 12 visits PCY	\$25 Copay	50%	\$25 Copay	50%
Naturopathy	\$30 Copay		\$30 Copay	
Massage Therapy* Inpatient: 8 days; Outpatient: 20 visits PCY	20% (Coinsurance only)		30% (Coinsurance only)	
DIAGNOSTIC SERVICES				
Outpatient Diagnostic X-ray and Lab Services	20% (Coinsurance only)	50%	30% (Coinsurance only)	50%
Mammography				
PHARMACY**				
Retail Pharmacy Up to 30-day supply	\$10/\$45/50%	In-network + 40%	\$10/\$45/50%	In-network + 40%
Mail Service Up to 90-day supply	\$25/\$112.50/45%		\$25/\$112.50/45%	
EMERGENCY CARE				
Emergency Room Care (copay waived if admitted)	\$100 Copay plus 20%		\$100 Copay plus 30%	
Ambulance Transportation Air - unlimited	20% (Coinsurance only)		30% (Coinsurance only)	
Ambulance Transportation Ground - \$5,000 PCY	20% (Coinsurance only)		30% (Coinsurance only)	
FACILITY CARE				
Inpatient & Outpatient Facility Care	20% (Coinsurance only)	50%	30% (Coinsurance only)	50%
Skilled Nursing Facility 45 days PCY				
MATERNITY including prenatal care				
	20% (Coinsurance only)	50%	30% (Coinsurance only)	50%
VISION CARE				
Routine Vision Exam one exam per 2 calendar years	Covered in full		Covered in full	
Vision Hardware per 2 calendar years	\$200 for frames, lenses and contact lenses		\$200 for frames, lenses and contact lenses	

† Family = 3x individual for the deductible and coinsurance maximum.

* Shared with physical, occupational and speech therapy; cardiac and pulmonary rehabilitation; and chronic pain.

** Cost share for generic/preferred/non-preferred brands. Benefit for generic drugs unlimited. Benefit for all brand-name drugs limited to \$3,000 per calendar year. ✎

Note: All coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracted with LifeWise Health Plan of Washington. Please note that this is a general summary. Your individual health plan contract will describe the actual terms, conditions and exclusions of coverage.